

		FOR OHF USE					

LL 1

**2000**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2000)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0041293</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>IHS CHICAGO AT GOVERNORS PARK</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>JAN 1 2000</u> to <u>DEC 31 2000</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
<b>Address:</b> <u>1420 S. BARRINGTON ROAD</u> <u>BARRINGTON</u> <u>60010</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
<b>County:</b> <u>COOK</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ <u>MARCH 28, 2001</u> (Type or Print Name) <u>PAM PALINKAS</u> (Title) <u>VICE PRESIDENT - FACILITY FINANCIAL SERVICES</u>	
<b>Telephone Number:</b> <u>(847)382-6664</u> <b>Fax #</b> <u>(847)382-6693</u>		<b>Paid Preparer</b> (Signed) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>( )</u> <b>Fax #</b> <u>( )</u>	
<b>IDPA ID Number:</b> <u>52-167989001</u>		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>Date of Initial License for Current Owners:</b> <u>11/08/95</u>			
<b>Type of Ownership:</b>			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input checked="" type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>STEPHEN K. STINNETTE</u> <b>Telephone Number:</b> <u>(410)773-5799</u>			

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK# 0041293 Report Period Beginning: JAN 1 2000 Ending: DEC 31 2000**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>75</u>	Skilled (SNF)	<u>75</u>	<u>27,450</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>75</u>	Intermediate (ICF)	<u>75</u>	<u>27,450</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>150</u>	TOTALS	<u>150</u>	<u>54,900</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>10,197</u>	<u>183</u>	<u>11,602</u>	<u>21,982</u>	8
9	SNF/PED					9
10	ICF	<u>4,795</u>	<u>14,708</u>	<u>1,583</u>	<u>21,086</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>14,992</u>	<u>14,891</u>	<u>13,185</u>	<u>43,068</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 78.45%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)Meals on Wheels

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 11/08/95

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 11/08/95 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified \_\_\_\_\_ and days of care provided 9,789Medicare Intermediary Blue Cross of Maryland

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31 Fiscal Year: 12/31

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

IHS CHICAGO AT GOVERNORS PARK

# 0041293

Report Period Beginning:

JAN 1 2000

Ending:

DEC 31 2000

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	302,014	22,295	8,708	333,017		333,017		333,017		1
2	Food Purchase		238,730		238,730		238,730	(29,512)	209,218		2
3	Housekeeping	151,131	27,673	1,906	180,710		180,710		180,710		3
4	Laundry	48,205	15,918		64,123		64,123		64,123		4
5	Heat and Other Utilities			152,190	152,190		152,190	3,330	155,520		5
6	Maintenance	58,840	22,383	43,370	124,593		124,593	6,150	130,743		6
7	Other (specify):*			21,394	21,394		21,394		21,394		7
8	<b>TOTAL General Services</b>	560,190	326,999	227,568	1,114,757		1,114,757	(20,032)	1,094,725		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			6,380	6,380		6,380		6,380		9
10	Nursing and Medical Records	2,974,644	238,967	255,477	3,469,088		3,469,088	40,496	3,509,584		10
10a	Therapy	663,695	25,131		688,826		688,826	2,840	691,666		10a
11	Activities	76,075	9,370	5,168	90,613		90,613		90,613		11
12	Social Services	108,442		3,624	112,066		112,066		112,066		12
13	Nurse Aide Training										13
14	Program Transportation			722	722		722	2,014	2,736		14
15	Other (specify):*										15
16	<b>TOTAL Health Care and Programs</b>	3,822,856	273,468	271,371	4,367,695		4,367,695	45,350	4,413,045		16
	<b>C. General Administration</b>										
17	Administrative			531,675	531,675		531,675	(437,935)	93,740		17
18	Directors Fees										18
19	Professional Services			43,560	43,560		43,560	23,400	66,960		19
20	Dues, Fees, Subscriptions & Promotions			94,336	94,336		94,336	(13,681)	80,655		20
21	Clerical & General Office Expenses	147,903	34,045	71,156	253,104		253,104	427,518	680,622		21
22	Employee Benefits & Payroll Taxes			698,966	698,966		698,966	219,623	918,589		22
23	Inservice Training & Education			5,257	5,257		5,257		5,257		23
24	Travel and Seminar			14,416	14,416		14,416	10,219	24,635		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			52,300	52,300		52,300	(32,755)	19,545		26
27	Other (specify):*			966	966		966		966		27
28	<b>TOTAL General Administration</b>	147,903	34,045	1,512,632	1,694,580		1,694,580	196,389	1,890,969		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	4,530,949	634,512	2,011,571	7,177,032		7,177,032	221,707	7,398,739		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number **IHS CHICAGO AT GOVERNORS PARK** #0041293 Report Period Beginning: **JAN 1 2000** Ending: **DEC 31 2000**

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			9,465	9,465		9,465	434,060	443,525			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes			409,571	409,571		409,571		409,571			33
34	Rent-Facility & Grounds			1,555,738	1,555,738		1,555,738	(1,555,738)				34
35	Rent-Equipment & Vehicles			132,104	132,104		132,104	146,961	279,065			35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			2,106,878	2,106,878		2,106,878	(974,717)	1,132,161			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		403,814	18,428	422,242		422,242		422,242			39
40	Barber and Beauty Shops			9,202	9,202		9,202		9,202			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			87,500	87,500		87,500		87,500			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		403,814	115,130	518,944		518,944		518,944			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	4,530,949	1,038,326	4,233,579	9,802,854		9,802,854	(753,010)	9,049,844			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name &amp; ID Number IHS CHICAGO AT GOVERNORS PARK

# 0041293

Report Period Beginning:

JAN 1 2000

Ending:

DEC 31 2000

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(29,143)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	434,060	30		9
10	Interest and Other Investment Income	(18)	17		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(369)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(800)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(20,472)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule SEE PAGE 5A	(1,399,884)	Var		29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (1,016,626)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	263,616	Various	34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 263,616		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (753,010)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

ID#

0041253

Report Period Beginning:

JAN 1 2000

Ending:

DEC 31 2000

NON-ALLOWABLE EXPENSES			Sch. V Line
	Amount	Reference	
1	EMPLOYEE PATIENT LOSS FUND	\$ (1,000)	1
2	HEALTH INSURANCE	22,804	22 2
3	WORKERS COMPENSATION	168,805	22 3
4	GENERAL LIABILITY INSURANCE	(30,239)	26 4
5	PROPERTY INSURANCE	(2,516)	26 5
6			6
7			7
8			8
9	BUILDING RENT	(1,555,730)	34 9
10			10
11			11
12			12
13			13
14			14
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17			17
18			18
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85			85
86			86
87			87
88			88
89			89
90	Total	(1,399,884)	90

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number IHS CHICAGO AT GOVERNORS PARK

# 0041293

Report Period Beginning:

JAN 1 2000

Ending:

DEC 31 2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(29,512)	0	0	0	0	0	0	0	0	0	0	(29,512)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	3,330	0	0	0	0	0	0	0	0	0	3,330	5
6	Maintenance	0	6,150	0	0	0	0	0	0	0	0	0	6,150	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(29,512)</b>	<b>9,480</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(20,032)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	40,496	0	0	0	0	0	0	0	0	0	40,496	10
10a	Therapy	0	2,840	0	0	0	0	0	0	0	0	0	2,840	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	2,014	0	0	0	0	0	0	0	0	0	2,014	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>45,350</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>45,350</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	(18)	(437,917)	0	0	0	0	0	0	0	0	0	(437,935)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	23,400	0	0	0	0	0	0	0	0	0	23,400	19
20	Fees, Subscriptions & Promotions	(20,472)	6,791	0	0	0	0	0	0	0	0	0	(13,681)	20
21	Clerical & General Office Expenses	(3,800)	431,318	0	0	0	0	0	0	0	0	0	427,518	21
22	Employee Benefits & Payroll Taxes	191,609	28,014	0	0	0	0	0	0	0	0	0	219,623	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	10,219	0	0	0	0	0	0	0	0	0	10,219	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(32,755)	0	0	0	0	0	0	0	0	0	0	(32,755)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	<b>TOTAL General Administration</b>	<b>134,564</b>	<b>61,825</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>196,389</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>105,052</b>	<b>116,655</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>221,707</b>	<b>29</b>



Facility Name &amp; ID Number IHS CHICAGO AT GOVERNORS PARK

# 0041293

Report Period Beginning: JAN 1 2000 Ending: DEC 31 2000

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Lyric LLC	100%	Exceptional Care	Burbank	Integrated Health Svcs	Baltimore	Home Office

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☒

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V	17	IHS Home Office Expense	\$ 437,917	Integrated Health Services, Inc.		\$	(437,917)	1
2	V	5	IHS Home Office Expense		Integrated Health Services, Inc.		3,330	3,330	2
3	V	6	IHS Home Office Expense		Integrated Health Services, Inc.		6,150	6,150	3
4	V	10	IHS Home Office Expense		Integrated Health Services, Inc.		40,496	40,496	4
5	V	14	IHS Home Office Expense		Integrated Health Services, Inc.		2,014	2,014	5
6	V	19	IHS Home Office Expense		Integrated Health Services, Inc.		23,400	23,400	6
7	V	20	IHS Home Office Expense		Integrated Health Services, Inc.		6,791	6,791	7
8	V	21	IHS Home Office Expense		Integrated Health Services, Inc.		431,318	431,318	8
9	V	22	IHS Home Office Expense		Integrated Health Services, Inc.		28,014	28,014	9
10	V	24	IHS Home Office Expense		Integrated Health Services, Inc.		10,219	10,219	10
11	V	32	IHS Home Office Expense		Integrated Health Services, Inc.				11
12	V	35	IHS Home Office Expense		Integrated Health Services, Inc.		146,961	146,961	12
13	V	10a	IHS Home Office Expense		Integrated Health Services, Inc.		2,840	2,840	13
14	Total			\$ 437,917			\$ 701,533	\$ * 263,616	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK # 0041293 Report Period Beginning: JAN 1 2000 Ending: DEC 31 2000

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK# 0041293

Report Period Beginning:

JAN 1 2000Ending: DEC 31 2000

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization INTEGRATED HEALTH SERVICES  
 Street Address 910 RIDGEBROOK ROAD  
 City / State / Zip Code SPARKS, MD 21152  
 Phone Number (410)773-5799  
 Fax Number (410)773-5830

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2	DIRECT TRACKING OF EXPENSES AND ALLOCATION OF POOLED COSTS BASED ON PERCENT OF TOTAL COSTS								2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related Long-Term																		
1	N/A						\$	\$			\$	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6												6							
7												7							
8												8							
9	TOTAL Facility Related						\$	\$			\$	9							
	B. Non-Facility Related*																		
10												10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$	14							
15	TOTALS (line 9+line14)						\$	\$			\$	15							

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **IHS CHICAGO AT GOVERNORS PARK**# **0041293** Report Period Beginning: **JAN 1 2000** Ending: **DEC 31 2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 1999 report.	\$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	\$	409,571	2
3. Under or (over) accrual (line 2 minus line 1).	\$	409,571	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	\$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>	\$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>	\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	\$	409,571	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1995	279,201	8		
	1996	284,146	9		
	1997	293,015	10	13	FROM R. E. TAX STATEMENT FOR 1999 \$ 13
	1998	378,641	11	14	PLUS APPEAL COST FROM LINE 5 \$ 14
	1999	398,499	12	15	LESS REFUND FROM LINE 6 \$ 15
				16	AMOUNT TO USE FOR RATE CALCULATION \$ 16

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

A. Square Feet:

34,765

B. General Construction Type:

Exterior

BRICK

Frame

STEEL

Number of Stories

1

C. Does the Operating Entity?

☐ (a) Own the Facility
 ☒ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY	34,765	1995	\$ 1,880,404	1
2					2
3	TOTALS	34,765		\$ 1,880,404	3

Facility Name &amp; ID Number IHS CHICAGO AT GOVERNORS PARK

# 0041293

Report Period Beginning:

JAN 1 2000 Ending: DEC 31 2000

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	150		1995	1985	\$ 7,322,291	\$ 367,297	20	\$ 367,297		\$ 1,884,291	4
5			1995	1985	3,080	77	40	77			5
6			1995	1985	112,197	3,631	40	3,631			6
7											7
8											8
9	<b>Improvement Type**</b>										
10	FLOORING		1997		2,000	100	20	100		400	9
11	UPGRADES/TILING/DOORS FOR VENTILATOR CAPABILITY		1997		32,786	1,639	20	1,639		6,556	10
12	PAINTING/ELECTRICAL		1997		3,899	260	15	260		1,040	11
13	FIRE SYSTEM REPAIR		1997		13,237	882	15	882		3,528	12
14	EMERGENCY CIRCUITS		1997		7,684	384	20	384		1,536	13
15	EMERGENCY CIRCUITS		1997		2,847	142	20	142		568	14
16	PAVEMENT RENOVATION		1997		1,141	114	10	114		456	15
17	ARCHITECTURAL DRAWINGS		1997		300	15	20	15		60	16
18	A/C COMPRESSOR		1997		3,153	158	20	158		632	17
19	AIR HANDLING WORK		1997		1,825	91	20	91		364	18
20	MERCURY SWITCH		1997		626	31	20	31		124	19
21	NURSE CALL SYSTEM		1997		628	31	20	31		124	20
22	FIRE SYSTEM		1997		640	32	20	32		128	21
23	PAINTING/ELECTRICAL		1997		4,150	208	20	208		832	22
24	ARCHITECTURAL		1997		300	15	20	15		60	23
25	WATER HEATER REPAIR		1998		3,200	320	10	320		960	24
26	NEW CONCRETE/LANDSCAPING FOR EROSION PREVENTION		1998		14,905	745	20	745		2,235	25
27	UPGRADE ROOM TO SUITE		1998		1,100	55	20	55		165	26
28	B WING PAINTING		1998		8,100	540	15	540		1,620	27
29	WASHER PLUS INSTALLATION		1998		15,664	1,044	15	1,044		3,132	28
30	DRIVEWAY REPAIRS		1999		4,450	556	8	556		1,112	29
31	FIRE SYSTEM ACCELERATOR		1999		4,700	470	10	470		1,880	30
32	FIRE SYSTEM REPAIR		1999		1,608	161	10	161		322	31
33	FLOORING		2000		2,343	171	10	171		171	32
34	REAR PARKING LOT REPAIR		2000		3,635	121	10	121		121	33
35											34
36	<b>TOTAL (lines 4 thru 35)</b>				\$ 7,572,489	\$ 379,290		\$ 379,290	\$	1,912,417	35

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	\$ 603,165	\$ 62,136	\$ 62,136	\$	10	\$ 299,040	37
38	Current Year Purchases	37,151	2,099	2,099		10	2,099	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	\$ 640,316	\$ 64,235	\$ 64,235	\$		\$ 301,139	41

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				\$	\$	\$	\$		\$	42
43										43
44										44
45										45
46	TOTALS			\$	\$	\$	\$		\$	46

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
47	Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	\$ 10,093,209	47
48	Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5)	\$ 443,525	48
49	Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6)	\$ 443,525	49
50	Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7)	\$	50
51	Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9)	\$ 2,213,556	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		\$	\$	\$	52
53					53
54					54
55					55
56					56
57	TOTALS	\$	\$	\$	57

G. Construction-in-Progress

	Description	Cost	
58		\$	58
59			59
60			60
61		\$	61

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

**XII. RENTAL COSTS**

**A. Building and Fixed Equipment (See instructions.)**

1. Name of Party Holding Lease: \_\_\_\_\_

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? \_\_\_\_\_

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease \_\_\_\_\_.

9. Option to Buy: ☐ YES ☐ NO Terms: \_\_\_\_\_ \*

**B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental? \_\_\_\_\_

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ **132,104** Description: \_\_\_\_\_

(Attach a schedule detailing the breakdown of movable equipment)

**C. Vehicle Rental (See instructions.)**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning \_\_\_\_\_

Ending \_\_\_\_\_

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2001 \$ \_\_\_\_\_

13. /2002 \$ \_\_\_\_\_

14. /2003 \$ \_\_\_\_\_

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**

<b>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</b>  <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	<b>2. CLASSROOM PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  COMMUNITY COLLEGE <input type="checkbox"/>  HOURS PER AIDE _____	<b>3. CLINICAL PORTION:</b>  IN-HOUSE PROGRAM <input type="checkbox"/>  IN OTHER FACILITY <input type="checkbox"/>  HOURS PER AIDE _____
---	---	--

**B. EXPENSES**

**ALLOCATION OF COSTS (d)**

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

**C. CONTRACTUAL INCOME**

In the box below record the amount of income your facility received training aides from other facilities.

\$ \_\_\_\_\_

**D. NUMBER OF AIDES TRAINED**

<b>COMPLETED</b>	
1. From this facility	
2. From other facilities (f)	
<b>DROP-OUTS</b>	
1. From this facility	
2. From other facilities (f)	
<b>TOTAL TRAINED</b>	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8						
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)						
			Units of Service	Cost	Units	Cost									
1	Licensed Occupational Therapist	10a 1	28814	hrs	\$	157,179		\$	28,814	\$	157,179	1			
2	Licensed Speech and Language Development Therapist	10a 1	7581	hrs		52,840			7,581		55,870	2			
3	Licensed Recreational Therapist	11 1	6509	hrs		76,075			6,509		76,075	3			
4	Licensed Physical Therapist	10a 1	48914	hrs		261,283			48,914		261,283	4			
5	Physician Care			visits								5			
6	Dental Care			visits								6			
7	Work Related Program			hrs								7			
8	Habilitation			hrs								8			
9	Pharmacy			# of prescripts				403,814			403,814	9			
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)			hrs								10			
11	Academic Education			hrs								11			
12	Exceptional Care Program											12			
13	Other (specify): RT (col. 1) X-RAY/LAB (col. 5)					116,318		15,398			131,716	13			
14	TOTAL				\$	663,695		\$	18,428	\$	403,814	91,818	\$	1,085,937	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$		1
2	Cash-Patient Deposits		988	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )		1,497,344	3
4	Supply Inventory (priced at cost )		167,145	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$	1,665,477	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		1,880,404	13
14	Buildings, at Historical Cost		7,470,613	14
15	Leasehold Improvements, at Historical Cost		101,876	15
16	Equipment, at Historical Cost		640,316	16
17	Accumulated Depreciation (book methods)		(2,213,556)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		397,189	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(7,216)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Intercompany Transfer		(1,246,421)	23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$	7,023,205	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$	8,688,682	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$	(511,016)	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable		130,243	30
31	Accrued Taxes Payable (excluding real estate taxes)		(1,418)	31
32	Accrued Real Estate Taxes(Sch.IX-B)		364,616	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36			12,789,871	36
37				37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$	12,772,296	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43	Intercompany Transfer		(2,197,485)	43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$	(2,197,485)	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$	10,574,811	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$	(1,886,129)	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$	8,688,682	48

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	\$ <b>(787,426)</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>			<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	\$ <b>(787,426)</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(1,098,703)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	( )	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ <b>(1,098,703)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>	<b>INTERCOMPANY TRANSFER</b>		<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ <b>(1,886,129)</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

**XVII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 9,751,023	1
2	Discounts and Allowances for all Levels	(6,673,175)	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	<b>\$ 3,077,848</b>	<b>3</b>
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,945,268	6
7	Oxygen	2,400	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	<b>\$ 2,947,668</b>	<b>8</b>
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	11,125	13
14	Non-Patient Meals	29,143	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	834,153	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	72,003	19
20	Radiology and X-Ray	3,055	20
21	Other Medical Services	1,727,210	21
22	Laundry	1,131	22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	<b>\$ 2,677,820</b>	<b>23</b>
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***		25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	<b>\$</b>	<b>26</b>
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>INTEREST INCOME</b>	<b>18</b>	28
28a	<b>MISCELLANEOUS REVENUE</b>	<b>794</b>	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	<b>\$ 812</b>	<b>29</b>
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	<b>\$ 8,704,148</b>	<b>30</b>

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,114,757	31
32	Health Care	4,367,695	32
33	General Administration	1,694,580	33
<b>B. Capital Expense</b>			
34	Ownership	2,106,878	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	431,444	35
36	Provider Participation Fee	87,500	36
<b>D. Other Expenses (specify):</b>			
37	<u>Rounding</u>	(3)	37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	<b>\$ 9,802,851</b>	<b>40</b>
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	<b>(1,098,703)</b>	<b>41</b>
42	<b>Income Taxes</b>		<b>42</b>
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	<b>\$ (1,098,703)</b>	<b>43</b>

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **IHS CHICAGO AT GOVERNORS PARK**

# 0041293

Report Period Beginning: JAN 1 2000

Ending:

DEC 31 2000

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,881	2,065	\$ 26,521	\$ 12.84	1
2	Assistant Director of Nursing					2
3	Registered Nurses	63,933	76,735	1,608,713	20.96	3
4	Licensed Practical Nurses	19,380	19,380	358,781	18.51	4
5	Nurse Aides & Orderlies	71,435	71,435	934,506	13.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	6,501	6,509	76,075	11.69	9
10	Activity Assistants					10
11	Social Service Workers	6,481	6,685	108,442	16.22	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	27,774	29,826	302,014	10.13	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	3,513	3,547	58,840	16.59	17
18	Housekeepers	18,187	19,940	151,131	7.58	18
19	Laundry	5,531	6,355	48,205	7.59	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	12,010	12,916	147,903	11.45	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	391	391	6,334	16.20	31
32	Other Health Care Therapy	29,941	31,873	663,695	20.82	32
33	Other(specify) Central Supplies	3,081	3,277	39,789	12.14	33
34	TOTAL (lines 1 - 33)	270,039	290,934	\$ 4,530,949 *	\$ 15.57	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	monthly	\$ 8,708	1 3	35
36	Medical Director	monthly	6,380	9 3	36
37	Medical Records Consultant	as needed	673	10 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	monthly	6,487	10 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 22,248		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	3,015	\$ 78,399	10 3	50
51	Licensed Practical Nurses	446	8,925	10 3	51
52	Nurse Aides	3,788	56,816	10 3	52
53	TOTAL (lines 50 - 52)	7,249	\$ 144,140		53

<b>Facility Name &amp; ID Number</b>	<b>IHS CHICAGO AT GOVERNORS PARK</b>
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## XIX. SUPPORT SCHEDULES

A. Administrative Salaries			
Name	Function	% Ownership	Amount
Lori Schuetz	Administrator	0	\$ 0
Pamela Lee	Administrator	0	0
(note - administrator is contractual position recorded in column 3)			
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 0
<b>B. Administrative - Other</b>			
Description			Amount
Lyric Management Fee			\$ 437,917
Contractual administrator positions			93,758
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 531,675
<b>C. Professional Services</b>			
Vendor/Payee	Type		Amount
Vinick & Docherty	Legal Fees		\$ 1,210
Credit	Software Support Fees		(533)
Sprint	Data Communications		1,951
Gordon Flesch, Baird	CPS		34,299
KPMG (Accrual)	Accounting Fees		6,633
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 43,560
<b>D. Employee Benefits and Payroll Taxes</b>			
Description			Amount
Workers' Compensation Insurance			\$ 276,694
Unemployment Compensation Insurance			33,959
FICA Taxes			337,351
Employee Health Insurance			230,165
Employee Meals			
Illinois Municipal Retirement Fund (IMRF)*			
Background Checks			
Other Employee Benefits			12,406
Home Office Costs			28,014
TOTAL (agree to Schedule V, line 22, col.8)			\$ 918,589
<b>E. Schedule of Non-Cash Compensation Paid to Owners or Employees</b>			
Description	Line #		Amount
			\$
TOTAL			\$
<b>F. Dues, Fees, Subscriptions and Promotions</b>			
Description			Amount
IDPH License Fee			\$
Advertising: Employee Recruitment			63,711
Health Care Worker Background Check (Indicate # of checks performed 118 )			1,887
Dues and Subscriptions			4,974
Advertising			20,472
Community Relations			3,292
Home Office Costs			6,791
Less: Public Relations Expense			( )
Non-allowable advertising			(20,472)
Yellow page advertising			( )
TOTAL (agree to Sch. V, line 20, col. 8)			\$ 80,655
<b>G. Schedule of Travel and Seminar**</b>			
Description			Amount
Out-of-State Travel			\$ 753
In-State Travel			10,952
Seminar Expense			1,422
Home Office Costs			10,219
Meals			1,289
Entertainment Expense			( )
TOTAL (agree to Sch. V, line 24, col. 8)			\$ 24,635

\* Attach copy of IMRF notifications

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
(See instructions.)**

[illegible]

Facility Name & ID Number IHS CHICAGO AT GOVERNORS PARK

STATE OF ILLINOIS

# 0041293

Report Period Beginning: JAN 1 2000

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Ending: DEC 31 200

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? No  
If YES, give association name and amount. \_\_\_\_\_
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10 years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 114,088 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES x NO \_\_\_\_\_ If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 87,500  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ \_\_\_\_\_ Has any meal income been offset against related costs? Yes Indicate the amount. \$ 29,143
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use?  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: KPMG The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? No If no, please explain. Audit not finished
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.